

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/17/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185137	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/06/2012
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NAME OF PROVIDER OR SUPPLIER WESTMINSTER TERRACE	STREET ADDRESS, CITY, STATE, ZIP CODE 2116 BUECHEL BANK ROAD LOUISVILLE, KY 40218
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F 000	INITIAL COMMENTS	F 000	Amended Plan of Correction	
F 309 SS=D	<p>A standard survey was conducted 04/03/12 - 04/06/12. A Life Safety Code survey was conducted on 04/04/12 with the highest scope and severity identified as an "F".</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and policy review, it was determined for nineteen (19) sampled and an unsampled resident, the facility failed to follow physician orders for one resident, Resident #A. The facility provided a straw to unsampled Resident #A, who had a "No straw" order to lower the risk of choking and aspiration when drinking.</p> <p>The findings include: No policy could be provided for following physician orders.</p> <p>Record review of Resident #A's orders dated for the month of 04/2012, revealed a diet order of "Pureed, No straw, No onion and No chocolate".</p> <p>Record review of Resident #A's meal ticket</p>	F 309	<p>Preparation and execution of this plan of correction does not constitute admission or agreement of any alleged deficiencies cited in this document. The plan of correction is prepared and executed as required under the provision of federal and state law. Further, Presbyterian Homes of Louisville reserves the right to dispute the deficiencies in any other forum as necessary.</p> <ol style="list-style-type: none"> The straw was removed from the tray of Resident #A. Staff was educated on tray card compliance by the Staff Development Coordinator. A review of MD orders, care plans, and tray cards by the Nurse Manager found that the deficient practice potentially affects 17 residents. A policy on physician orders has been identified in the facility policy and procedure manual. Straws are no longer included when rolling silverware. Based on MD orders, CNA Care Guides and tray cards have been updated to include "No Straw". The facility has introduced an identification system for residents who have an order for "No Straw", are on thickened liquids, or are a choking risk with drinks. Mandatory Nursing in-services on these systemic changes were completed April 22nd - April 24th. 	5/3/12

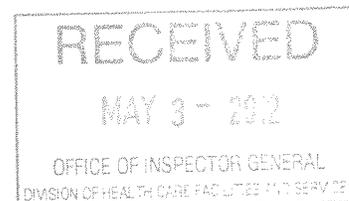
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Executive Director	(X6) DATE 5/3/12
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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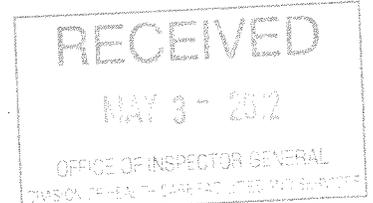
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F 309	<p>Continued From page 1</p> <p>revealed in dark letters "No Straws". Record review of the Dysphagia Evaluation, dated 12/7/11, revealed staff would follow safe swallow strategies during feedings to lower the risk of aspiration.</p> <p>Observation of Resident #A, on 04/03/12 at 12:42 PM, revealed Resident #A had a straw in his/her glass of water and milk. A CNA (Certified Nursing Assistant) #4 was observed providing milk to the resident with a straw. Observation of Resident #A, on 04/06/12 at 9:12 AM, revealed Resident #A drinking from a straw in a carton of milk.</p> <p>Interview with CNA #4, on 04/03/12 at 12:46 PM, revealed she was educated to look at meal tickets. Resident #A was not to have any straws because he/she may choke.</p> <p>Interview with the Speech Therapist, on 04/06/12 at 9:30 AM, revealed safe swallow strategies meant small bites, clearing of the oral cavity before the next bite was given, verbal and tactile cues to swallow. The Speech Therapist further stated, always make sure the resident was positioned up right with ninety (90) degree flexion. Resident #A was coughing and choking on all consistencies, because Resident #A was on thin liquids and no straws was ordered. The use of straws would cause the liquid to shoot to the back of the throat with greater risk of aspiration.</p> <p>Interview with the Director of Nursing (DON), on 04/06/12 at 11:40 AM, revealed staff were taught to look at meal tickets and were in-serviced annually. The DON stated Resident #A had some sort of swallowing difficulty. The DON further stated, Resident #A may drink to quick and cause</p>	F 309	<p>4. An audit of physician order/tray card compliance of 10 residents will be conducted weekly by Staff Development and provide copies of all audits to the Administrator and Director of Nursing for review and appropriate follow up. Any concerns identified will be addressed immediately by the Staff Development Coordinator and reported to the Administrator and Director of Nursing for further investigation including the introduction of further corrective actions. Once 100% compliance has been achieved during four (4) consecutive weeks, the audits will reduce to monthly. Results of the audits will be reported to the QA committee monthly until 100% compliance has been achieved for three (3) consecutive months, then upon QA committee recommendation the audit reports will be reduced to quarterly. The Administrator will audit and review one meal per week as a permanent, systemic change. The change will become a part of the routine facility audit process performed by the Administrator. Further recommendations will be made by the QA committee based upon audit finding.</p>	



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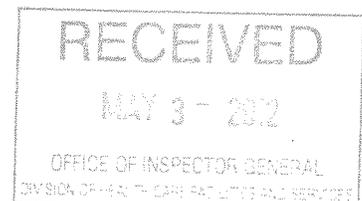
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F 309	Continued From page 2	F 309			
F 371 SS=F	<p>aspiration if he/she was to use a straw.</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, and review of the facility policies: Food Receiving and Storage and Preventing Food-borne Illness-Employee Hygiene and Sanitary Practices, it was determined the facility failed to serve and prepare food in a sanitary manner. Two (2) male employees were observed in the food prep area and serving food without a facial hair restraint. Food items were found stored in the freezer uncovered and not dated. The basement freezer was observed to have water dripping from the ceiling and later to have ice formations on both the ceiling and the floor of the freezer. This was a repeat deficiency.</p> <p>The findings include:</p> <p>Review of the facility's policy Food Receiving and Storage, dated 12/2011, revealed all foods stored in the refrigerator or freezer will be covered, labeled and dated.</p>	F 371	<ol style="list-style-type: none"> The two male dietary employees immediately placed beard nets on. Food items stored in the freezer were covered and dated. Vittitow Refrigeration was contacted to repair the basement freezer. All residents were observed by nursing staff on all shifts for signs of exposure to contaminated foods. No action necessary at this time. Mandatory Dietary In-services have been completed on sanitation practices. The Assistant Dietary Director/Kitchen Manager will complete a daily audit of food storage for appropriate dating and covering. The Assistant Dietary Director/Kitchen Manager will also complete a daily audit of one meal for use of beard nets. The consultant Dietician will perform sanitation audits weekly. Vittitow Refrigeration is in process of replacing the thermostat in the basement freezer to correct the water drip and ice formation. The part is currently on back order and expected to arrive by May 1st. Repairs will be completed by May 4th. Mandatory Dietary in-services on these systemic changes were completed April 23rd and 24th. 	<p>5/3/12</p> <p>5-5-12</p> <p>RN Craig</p> <p>By RB</p> <p>5-9-12</p>	



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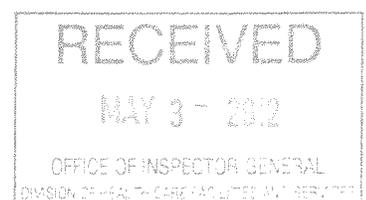
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F 371	<p>Continued From page 3</p> <p>Review of the facility's policy Preventing Food-borne Illness-Employee Hygiene and Sanitary Practices, dated 12/2011, revealed hair nets or caps and /or beard restraints must be worn in food preparation areas to keep hair from contacting exposed food, clean equipment, and utensils.</p> <p>1. Observation during lunch meal service on the first floor south dining room, on 04/03/12 at 12:20 PM, revealed the Assistant Food Service Director serving dessert to residents without a facial hair restraint covering his beard and mustache.</p> <p>Observation of the kitchen during lunch food preparation and temperature checks, on 04/04/12 at 12:10 PM, revealed the Assistant Food Service Director walking around the kitchen and assisting dietary staff without a facial hair restraint covering his beard and mustache.</p> <p>Interview with the Food Service Worker, on 04/05/12 at 1:40 PM, revealed he was not wearing a facial hair restraint while serving resident food. The Food Service Worker revealed a potential for the hair to fall into the food. He revealed he did not normally wear a facial hair restraint while working in the kitchen or when working the tray line in the dining room.</p> <p>Interview with the Assistant Food Service Director, on 04/05/12 at 1:43 PM, revealed he was trained on wearing hair restraints and was aware of the facility's policy for facial hair restraints. The Assistant Food Service Director revealed a potential for hair to fall into the food. However, he revealed hair was all over the body</p>	F 371	<p>4. Any deficient practices identified by the Assistant Dietary Manager, Kitchen Manager, and/or Dietician will be immediately corrected and reported to the Director of Food Services and Administrator for follow up to ensure corrective action is completed. Results of the daily audits completed by the Assistant Dietary Director will be reviewed weekly by the Food Service Director and presented monthly to the QA committee. Once 100% compliance has been achieved during four (4) consecutive weeks, the audits will reduce to monthly. Results of the audits will be reported to the QA committee monthly for until 100% compliance has been achieved for three (3) consecutive months, and then upon recommendation of the QA committee the audits will be reduced to quarterly. The Administrator will audit and review one meal per week as a permanent, systemic change. The change will become a part of the routine facility audit process performed by the Administrator. Further recommendations will be made by the QA committee based upon audit findings.</p>	



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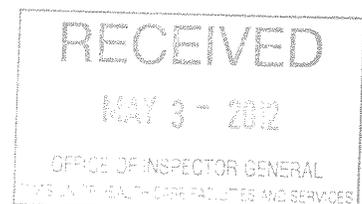
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F 371	<p>Continued From page 4</p> <p>and it should not be a concern. The Assistant Director revealed as a manager he was responsible for monitoring the staff for facial hair restraints, he stated he had not noticed an issue, but also revealed he was not a good role model for the employees.</p> <p>Interview with the Food Service Director, on 04/05/12 at 1:55 PM, revealed he was aware that facial hair restraints was a repeat deficiency and revealed he had written the plan of correction. The Food Service Director revealed he placed the Assistant Food Service Director in charge of the daily monitoring, and he had not noticed the Assistant Director did not wear a restraint. The Director revealed a potential for food contamination by not wearing facial hair restraints. The Food Service Director revealed there has not been an in-service regarding facial hair restraints for the employees.</p> <p>2. Observation of the walk-in kitchen freezer during initial tour, on 04/03/12 at 8:50 AM, revealed a box of chicken breast tenderloin fritters, a box of pork fritters, and a box of beef steak burgers opened, unsealed, and not dated.</p> <p>Interview with the Food Service Director, on 04/05/12 at 1:55 PM, revealed a potential for airborne contamination to food not properly sealed and stored in the freezer. The Food Service Director revealed the last in-service was two weeks prior to survey. The Food Service Director revealed he does monitor for storage of food items during a daily walk through. He revealed there was a rubric rounding tool but does not sign that it was completed.</p>	F 371		



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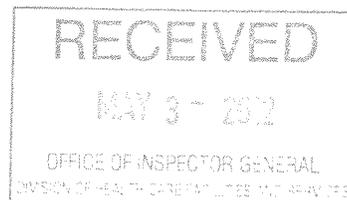
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F 371	<p>Continued From page 5</p> <p>3. Observation of the walk-in freezer in the basement during initial tour, on 04/03/12 at 9:10 AM, revealed areas of ice on the floor and puddles of water. Water droplets noted to the ceiling of the freezer and dripping onto the floor. Observation of basement freezer, on 04/05/12 at 1:30 PM, revealed cone shaped ice formations on the ceiling of the freezer and large areas of ice were noted to the floor of the freezer.</p> <p>Interview with the Assistant Maintenance Director, on 04/06/12 at 9:20 AM, revealed he was not aware of problems with the basement freezer. The Assistant Director revealed he does not routinely check on the freezer, and revealed dietary monitors the freezer and notifies them if the freezer was in need of repair. The Assistant Maintenance Director revealed water should not be dripping from the ceiling and there should not be a build up of ice on the floor.</p> <p>Review of the Dietary Report and Monthly Audit, dated 03/26/12, revealed opportunities for improvement included ice build up in the basement freezer.</p> <p>Interview with the Food Service Director, on 04/06/12 at 9:30 AM, revealed the freezer had always worked in that manner and it was monitored. The Food Service Director revealed he did not allow it to get too built up and that was the reason they kept a sledge hammer near by. The Food Service Director revealed a potential problem for food contamination with the dripping water and ice accumulation in the freezer. Observation, on 04/04/12 at 11:50 AM, revealed the Food Service Worker was behind the steam</p>	F 371			



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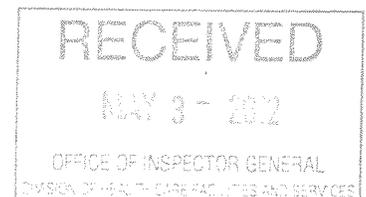
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F 371	Continued From page 6 table line area on the second floor with out a facial hair covering his facial hair. Observation, on 04/04/12 at 11:57 AM, revealed the Assistant Dietary Director was behind the steam table line area on the second floor with out a facial hair covering his facial hair. Observation, on 04/05/12 at 8:30 AM, revealed the Food Service Worker was found serving the breakfast meal to residents from the second floor steam table line area with facial hair without a facial hair covering. Interview, on 04/05/13 at 1:30 PM, revealed the Assistant Dietary Director had not worn a facial hair covering while serving residents from the second floor steam table line area. He further stated it was the facility policy for staff to wear facial hair coverings and the facility was provided with training. The Assistant Dietary Director stated it was possible that facial hair could fall into the food that was served to the facility residents. He stated it was his responsibility to ensure facility staff wear hair coverings as well as the Dietary Manager.	F 371			
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 431			



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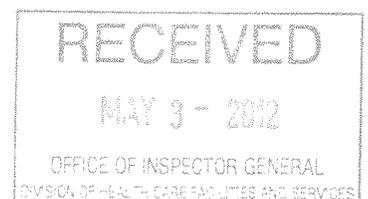
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F 431	<p>Continued From page 7</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to ensure drugs and biologicals used in the facility were monitored for expiration dates in one (1) of two (2) medication rooms. The first floor medication room's Emergency Drug Kit (EDK) for intravenous (IV) supplies contained ten (10) of ten (10) pre-filled heparin flushes that were expired 03/2012.</p> <p>The findings include:</p>	F 431	<ol style="list-style-type: none"> The IV EDK box was removed and returned to pharmacy. A new IV EDK box was dispensed and delivered. At the time the deficient practice was identified, no residents were receiving heparin. Upon delivery, the IV EDK box will be opened by desk nurse on duty at the time and expiration dates audited. A copy of this audit will be provided to the Director of Nursing for review and follow up with pharmacy as necessary regarding any identified concerns. Any expired medications will be noted and returned immediately to the pharmacy. The consultant pharmacist will audit the IV EDK monthly and provide a copy of the audit to the Administrator for review and appropriate follow up with pharmacy on any identified concerns. A new IV EDK will automatically be dispensed monthly from the pharmacy. Mandatory Nursing in-services on these systemic changes were completed April 22nd – April 24th 	5/3/12



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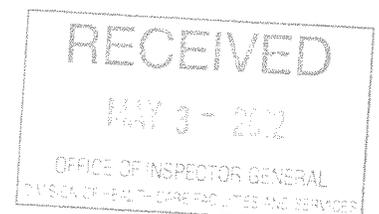
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F 431	<p>Continued From page 8</p> <p>The facility policy, Emergency Medications, revised April 2007, revealed the consultant pharmacist shall inspect the emergency medication kits monthly and record the findings; and records of monthly inspections were maintained for at least one (1) year.</p> <p>The facility did not provide records of monthly inspections of the EDK box.</p> <p>Observation, on 04/06/12 at 8:45 AM, revealed the EDK box in the first floor medication room contained ten (10) of ten (10) pre-filled heparin flush syringes which had expired 03/2012 contained in a zip top bag with a label dated 04/2012 and a label on the outside of the EDK box dated 04/2012.</p> <p>Interview, on 04/06/12 at 8:45 AM, with Licensed practical Nurse (LPN) #6 revealed the pharmacy was responsible to check expiration dates of medications in the EDK box. The LPN stated the pharmacy was responsible for the labels on the zip bag and outside box which were dated 04/2012.</p> <p>On 04/06/12 at 9:40 AM, interview with the Nurse Manager revealed the heparin flushes were supplied by pharmacy and the pharmacy was responsible to check the EDK box expiration dates and to replace what was used. She stated when the EDK box was replaced the pharmacy delivered a complete and sealed kit. The Nurse Manager stated the pharmacy labeled the zip bag and outside box with the expiration date 04/2012. She stated if expired heparin was administered a resident could have a reaction to it. The Nurse</p>	F 431	<p>4. The Administrator will review audits of the IV EDK performed by nursing staff and the consultant pharmacist monthly as a permanent, systemic change. The change will become a part of the routine facility audit process performed by the Administrator. Any identified deficiencies will be addressed with the Director of Nursing and the pharmacy including modifications to the plan of correction as necessary. Audits will be provided to the QA committee for review monthly. Once compliance has been achieved for three (3) consecutive months, audit reports will be reduced to quarterly indefinitely as a part of the QA committee review of facility standards. Further recommendations will be made by the QA committee based upon audit findings.</p>		



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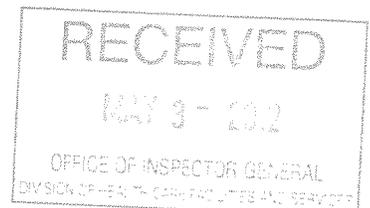
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185137	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/06/2012
NAME OF PROVIDER OR SUPPLIER WESTMINSTER TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2116 BUECHEL BANK ROAD LOUISVILLE, KY 40218		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 431	Continued From page 9 Manager stated no one at the facility monitors the EDK box and the box was not opened unless an item was used. Interview, on 04/06/12 at 10:40 AM, with the Assistant Director of Nursing (ADON) revealed the pharmacy monitors the EDK box and no one at the facility checks the EDK box. Interview, on 04/06/12 at 11:00 AM, with the Consultant Pharmacist revealed a technician from the pharmacy monitors the EDK box and verifies expiration dates of the contents. The Pharmacist stated the pharmacy technician who reviewed the contents of the EDK box labeled the zip bag and outside of the box with the expiration date of 04/2012. He stated there was no schedule to monitor the EDK box other than the expiration date on the outside of the box which was good until the end of the month. The pharmacist stated he does not inspect the EDK box. On 04/6/12 at 11:45 AM, interview with the Director of Nursing (DON) revealed the pharmacy was responsible to maintain the EDK box. The DON stated there was not a process in place to monitor the EDK box expiration dates and using expired heparin flush could cause an adverse reaction. Interview, on 04/06/12 at 12:25 PM, with the Executive Director revealed the facility did not have records of the monthly inspections of the EDK box.	F 431			
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an	F 441			



DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

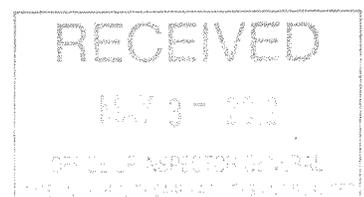
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F 441	Continued From page 10 Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced	F 441	1. RN #1, LPN#1, LPN #2, LPN #4, and LPN #5 were educated by the Staff Development Coordinator on 4/6/12 regarding infection control practices and hand washing technique. 2. A review of all residents with active infections found no evidence of the infection being associated with this deficient practice. 3. Mandatory Nursing In-services have been completed on infection control practices, policies, and procedures. The Staff Development Coordinator will complete a weekly infection control practice observation with ten (10) nurses/aides each week. The results of this review will be provided to the Director of Nursing for monitoring, follow up and direction of further staff education needs related to infection control as well monitoring of staff compliance with facility infection control program. Any deficient practices will be corrected immediately. Mandatory Nursing in-services on these systemic changes were completed April 22 nd - April 24 th	5/3/12



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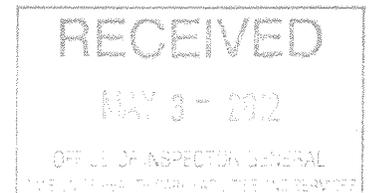
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F 441	Continued From page 11 by: Based on observation, interview, review of the CDC (Center for Disease Control) guidelines for Handwashing techniques, CDC Guideline for Hand Hygiene in Health-Care Settings, the facility's policy and procedure for hand hygiene, it was determined the facility failed to have an effective infection control program regarding hand hygiene for five (5) of nineteen (19) sampled residents (Residents' #2, #3, #6, #7, and #8). After contact with Resident #2 the nurse failed to wash her hands after removing her gloves. During a dressing change and skin assessment for Resident #3, a nurse was observed not washing hands after changing her gloves. During a dressing change for Resident #6, the nurse failed to change her gloves and wash her hands after removing a soiled dressing and she also failed to change her gloves in between both of the same resident's heel treatments. During skin assessments for Residents' #7 and #8, the nurses failed to wash their hands prior to putting on gloves. The findings include: The facility policy, Handwashing/Hand Hygiene revised April 2010, revealed staff should follow handwashing procedures to help prevent the spread of infection to others. Staff should wash hands: 1) before and after direct resident contact; 2) before and after changing a dressing; 3) after assisting a resident with toileting; 4) after handling soiled dressings; 5) after removing gloves; and 6) the use of gloves does not replace handwashing. The facility policy, Dressings Dry/Clean revised October 2010, revealed hands should be washed prior to putting on gloves and after removing a	F 441	4. The Administrator will review infection control audits monthly as a permanent, systemic change. The change will become a part of the routine facility audit process performed by the Administrator. The Staff Development Coordinator and/or Administrator will address any identified deficiencies with the Director of Nursing including modifications to the plan of correction as necessary. Results of the Infection Control Observations will be provided to the QA committee monthly. Once 100% compliance has been achieved during four (4) consecutive weeks, the audits will reduce to five (5) nurses/aides per week. Further recommendations will be made by the QA committee based upon audit findings.		



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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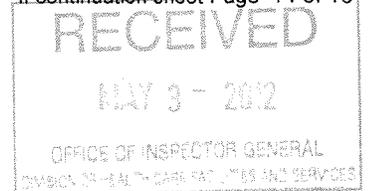
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F 441	<p>Continued From page 12 soiled dressing.</p> <p>Review of the CDC Guidelines for Hand Hygiene in Health-Care Settings, dated 10/25/02, revealed the following indications for handwashing and hand antisepsis: decontaminate hands before having direct contact with patients; decontaminate hands after contact with body fluids or excretions, mucous membranes, non-intact skin, and wound dressings; change gloves during patient care if moving from a contaminated body site to a clean body site; decontaminate hands after removing gloves; and decontaminate hands after having contact with inanimate objects in the immediate vicinity of the patient.</p> <p>1. Interview with RN #1 on 04/04/12 at 11:20 AM, revealed she was aware of the facility policy to wash hands before and after resident contact/treatments and further stated everybody knows you should wash your hands.</p> <p>Observation on 04/04/12 at 11:40 AM, revealed during Resident # 7's skin assessment RN (Registered Nurse) #1 failed to wash her hands prior to putting on gloves.</p> <p>2. Observation on 04/04/12 at 9:15 AM, revealed during Resident #8's skin assessment LPN (License Practical Nurse) #5 failed to wash her hands prior to putting on gloves.</p> <p>Interview with LPN #5 on 04/05/12 at 1:20 PM, revealed the facility policy was for facility staff to wash their hands before putting on gloves. LPN #5 stated the facility provided training to staff last year which included watching a video and</p>	F 441			



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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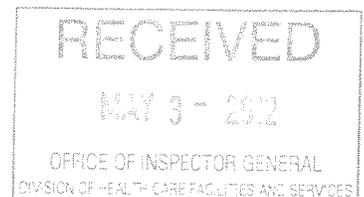
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F 441	<p>Continued From page 13</p> <p>completing a test. She further stated she was not aware of any facility management staff observing facility staff performing hand washing/hygiene. LPN #5 revealed the risk to facility residents from the lack of hand washing/hygiene was transferring any kind of germs to facility residents and staff.</p> <p>3. Observation of Resident #2's skin assessment conducted by LPN #4, on 04/02/12 at 10:39 AM, revealed after the head-to-toe skin assessment was completed, LPN #4 proceeded to take her gloves off, placed them in the garbage can, and wheeled Resident #2's roommate out into the hallway with out washing her hands.</p> <p>Interview with LPN #2, on 04/02/12 at 10:39 AM, revealed she did take her gloves off with out washing her hands. She stated she had just got caught up in trying to help the aid by assisting Resident #2's roommate out into the hall. LPN #2 further stated she should have washed her hands, especially after assessing a resident's peri area. We wash our hands so that if bacteria was left on our hands, we could remove it.</p> <p>Interview with the First Floor Charge Nurse, on the 04/06/12 at 9:45 AM, revealed nurses were trained to wash hands after taking their gloves off. The Charge Nurse stated we wash our hands to prevent infection.</p> <p>Interview with the Director of Nursing (DON), on 04/06/12 at 11:40 AM, revealed nurses were to wash their hands to prevent bacteria and germs from being transmitted. The nurses know to wash their hands and have been trained. The DON further stated she was responsible to make sure</p>	F 441			



DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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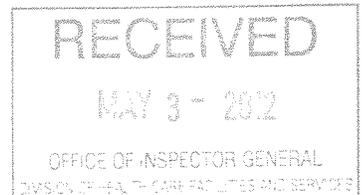
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F 441	<p>Continued From page 14</p> <p>the nurses were following proper infection control parameters.</p> <p>4. Observation, on 04/04/12 at 10:35 AM, revealed Registered Nurse (RN) #1 did not wash her hands when changing gloves during a skin assessment for Resident #3. The nurse changed gloves five (5) times without washing her hands, including after cleaning the resident of stool, after removing a soiled dressing, prior to cleansing and providing treatment to wounds, and prior to performing catheter care.</p> <p>Interview, on 04/04/12 at 11:20 AM, with RN #1 revealed hands should be washed before and after treatment and anytime gloves were changed to prevent cross-contamination. She stated the facility had not provided her training to wash hands when changing gloves.</p> <p>5. Observation, on 04/05/12 at 10:05 AM, revealed Licensed Practical Nurse (LPN) # 1 did not change gloves or wash hands during a G-tube dressing change and heel treatment for Resident #6. The nurse removed the soiled dressing around the G-tube, cleaned around the G-tube site, and applied a clean dressing using the same gloves. The LPN then washed her hands and changed her gloves and applied a Granulex treatment to both of the resident's heels using the same gloves.</p> <p>Interview, on 04/05/12 at 10:15 AM, with LPN #1 revealed she should have washed her hands and changed gloves after removing the soiled G-tube dressing and prior to applying a clean dressing due to the potential to spread infection. The nurse stated she should have washed her hands and</p>	F 441		



DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 441	<p>Continued From page 15</p> <p>changed gloves after applying the Granulex treatment to one (1) heel and prior to applying it to the other heel due to risk of contamination.</p> <p>Interview, on 04/06/12 at 9:40 AM, with the Unit Manager (UM) revealed staff were trained to wash hands anytime they changed gloves. She stated not washing hands could pass infection to others and was unsanitary. The UM stated she does not monitor hand washing.</p> <p>On 04/06/012 at 11:30 AM, interview with the Staff Development Coordinator/Infection Control Nurse revealed all staff were trained to wash hands when changing gloves and not washing hands could introduce bacteria. She stated staff were not monitored for hand washing during skin assessments or dressing changes and she was responsible to monitor hand washing as the infection control nurse.</p> <p>Interview, on 04/06/12 at 11:45 AM, with the Director of Nursing (DON) revealed the staff were trained to wash hands and the Staff Development Coordinator was responsible to monitor hand washing. She stated hand washing was to prevent the spread of bacteria and infection. The DON stated she was ultimately responsible to ensure staff followed infection control procedures.</p>	F 441		



DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1977</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: S/NF</p> <p>TYPE OF STRUCTURE: Two (2) stories, Type II Unprotected.</p> <p>SMOKE COMPARTMENTS: Three (3) smoke compartments on each floor.</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic, wet sprinkler system.</p> <p>GENERATOR: Type II, 60 KW generator. Fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 04/04/12. Westminster Terrace was found not in compliance with the requirements for participation in Medicare and Medicaid.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)</p> <p>Deficiencies were cited with the highest</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *X* _____ TITLE *X Executive Director X* (X6) DATE *5/3/12*

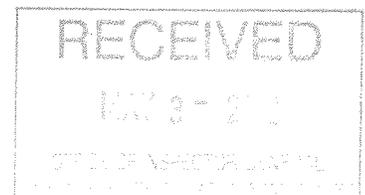
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

OFFICE OF INSPECTOR GENERAL

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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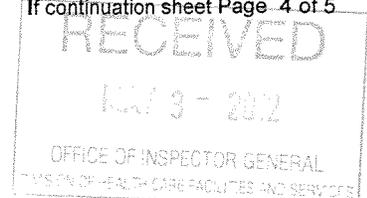
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K 000 K 130 SS=D	<p>Continued From page 1 deficiency identified at F level.</p> <p>NFPA 101 MISCELLANEOUS</p> <p>OTHER LSC DEFICIENCY NOT ON 2786</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain doors within a required means of egress, in accordance with NFPA standards. The deficiency had the potential to affect each of the six (6) smoke compartments, residents, staff, and visitors. The facility is licensed for one-hundred and twelve (112) beds and the census was ninety-one (91) on the day of the survey.</p> <p>The findings include:</p> <p>Observations, on 04/04/12 at 11:30 AM, with the Assistant Director of Maintenance revealed unapproved locks (pad lock type) were installed on two (2) doors located in the Dietary Storage Room located in the basement.</p> <ol style="list-style-type: none"> 1. A padlock on the entrance door from the corridor. 2. A padlock on the exit door to the exterior of the building. <p>Interview, on 04/04/12 at 11:30 AM, with the Assistant Director of Maintenance revealed he was aware of the locks installed on the doors; however, he was not aware that pad locks were prohibited by Code. He agreed with the</p>	K 000 K 130	<ol style="list-style-type: none"> 1. The padlocks on the entrance and exit doors were removed. 2. Upon review due to the location of this room, there is not a possibility of a resident being affected by this deficient practice. 3. The padlocks were removed and keyed door handles were placed. These handles lock on the outside and remain unlocked inside the room. Education of maintenance staff on NFPA101 was completed by the Director of Maintenance on 5/2/12. 4. Maintenance has reviewed the facility and no other padlocks are in place on doors. This review will be added to monthly safety rounds performed by the Director of Maintenance to ensure that padlocks do not get placed on egress doors. Any deficient practices will be corrected immediately by the Director of Maintenance. The safety rounds are a permanent change which will continue as an unending procedure for the facility. Results of the safety rounds will be provided to the Administrator monthly and appropriate follow up provided including further education or modification of our plan of correction. The Administrator will perform a quarterly safety audit as a permanent, systemic change. The change will become a part of the routine facility audit process performed by the Administrator. The results of the safety audits are provided to QA committee quarterly. Further recommendations will be made by the QA committee based upon audit findings. 	5/3/12



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 144	Continued From page 3 Observation, on 04/04/12 at 10:45 AM, with the Assistant Director of Maintenance revealed the facility was equipped with an emergency generator. The generator was not equipped with an annunciation panel in an area that was readily observed to make staff aware of alarm conditions with the generators. Interview, on 04/04/12 at 10:45 AM, on site with the Assistant Maintenance Director, and by telephone with the Director of Environmental Services revealed they were not aware the generator needed an annunciation panel to inform staff of alarm conditions of the emergency power source. Reference: NFPA 99 (1999 Edition). 3-4.1.1.15 + Alarm Annunciator. A remote annunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station (see NFPA 70, National Electrical Code, Section 700-12.) The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows: a. Individual visual signals shall indicate the following: 1. When the emergency or auxiliary power source is operating to supply power to load 2. When the battery charger is malfunctioning b. Individual visual signals plus a common	K 144	1. The generator company was contacted immediately to begin the process of installation of the annunciator panel. 2. Upon review of the facility, no residents have been affected by this deficient practice. 3. Varitech, generator maintenance company, has installed the new annunciator panel in the health care center directly across from the first floor nurses station. Installation was completed on 4/24/12. Maintenance and nursing staff were educated on 4/25/12 by the Assistant Director of Maintenance on how to read the panel and when to notify maintenance personnel based upon panel readings. Education of the Assistant Director of Maintenance on NFPA 99 was completed on 5/2/12 by the Director of Maintenance.	5/3/12



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 144	Continued From page 4 audible signal to warn of an engine-generator alarm condition shall indicate the following: 1. Low lubricating oil pressure 2. Low water temperature (below those required in 3-4.1.1.9) 3. Excessive water temperature 4. Low fuel - when the main fuel storage tank contains less than a 3-hour operating supply 5. Overcrank (failed to start) 6. Overspeed Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur, but need not display these conditions individually. [110: 3-5.5.2]	K 144	4. Maintenance will add monitoring operation of the annunciator panel to monthly safety reviews performed by the Director of Maintenance. Any deficient practices will be corrected immediately by the Director of Maintenance. The safety rounds are a permanent change which will continue as an unending procedure for the facility. Results of the safety rounds will be provided to the Administrator monthly and appropriate follow up provided including further education or modification of our plan of correction. Safety audit results will be provided to the QA committee quarterly. The Administrator will perform a quarterly safety audit as a permanent, systemic change. The change will become a part of the routine facility audit process performed by the Administrator. Further recommendations will be made by the QA committee based upon audit findings.	
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